BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:	)	
Julio Victor Guzman, M.D.	)	**Case No. 800-2014-010001**
Physician's and Surgeon's Certificate No. A 66211	)	
Respondent	)	

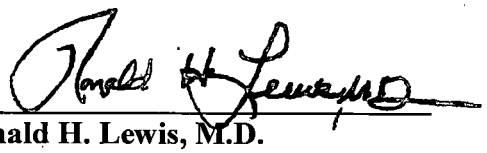
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on December 29, 2017.

IT IS SO ORDERED: November 29, 2017.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D.
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation against:	Case No. 800-2014-010001
JULIO VICTOR GUZMAN, M.D.,	OAH No. 2017031098
Physician's and Surgeon's Certificate No. A 66211	
Respondent.	

PROPOSED DECISION

Matthew Goldsby, Administrative Law Judge with the Office of Administrative Hearings, heard this matter on September 18-21, 2017, at Los Angeles, California.

Christine R. Friar, Deputy Attorney General, appeared and represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

Anthony K. McClaren, Attorney at Law, appeared and represented respondent Julio Victor Guzman, M.D.

After presenting evidence and legal argument, the parties submitted the matter for decision at the conclusion of the hearing on September 21, 2017.

FACTUAL FINDINGS

Jurisdiction and License History

1. On February 23, 2017, while acting in her official capacity, complainant brought the Accusation against respondent. Respondent timely submitted a Notice of Defense.

2. On September 7, 2017, complainant filed and served the First Amended Accusation. The additional allegations and issues raised in the amended pleading were

deemed controverted. Respondent waived his right to additional time to prepare a defense to any new charges raised in the First Amended Accusation. (Gov. Code, § 11517.)

3. On August 7, 1998, the Board issued Physician's and Surgeon's Certificate number A66211 to respondent. The certificate is valid and is scheduled to expire on July 31, 2018.

4. Respondent attended medical school at the University of San Carlos Faculty of Medical Science in Guatemala City, Guatamala. He came to the United States when he was 32 years of age. He took English as a Second Language (ESL) courses at Cerritos College while studying for the Board's examination for licensure. Currently, he is in private practice, operating a 1,200-square-foot clinic on Beverly Boulevard in Los Angeles, serving an adult clientele of a mostly poor socioeconomic status. He is certified in Family Practice, and has hospital privileges in good standing at St. Vincent Medical Center and Good Samaritan.

5. The Board has no record of disciplinary action against respondent's certificate. (Ex. 2.)

6. On November 20, 2014, the Board received an internal complaint that respondent was overprescribing medication to patients. On December 24, 2014, investigator Jack Sun was assigned to investigate the complaint. On July 24, 2015, the case was reassigned to Elizabeth Costello (Investigator Costello).

Standard of Care – in General

7. The standard of care for a given profession is a question of fact and in most circumstances must be proven through expert witnesses.[1] *(Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App.4th 208, 215; see 6 Witkin, *Summary of California Law* (9th Ed.), *Torts*, sections 749, 750, and 774.)

8. To establish the standard of care applicable in this case, complainant presented the expert opinion of Lawrence Dardick, M.D., licensed by the Board as a physician and surgeon. Dr. Dardick attended medical school at the University of Connecticut, School of Medicine. He completed his internship at the University of North Carolina, and his residency in family medicine at the University of California, Los Angeles (UCLA). Dr. Dardick is certified in family medicine.

9. Respondent presented the expert opinion of Alan C. Jasper, M.D., who is also licensed by the Board as a physician and surgeon. Dr. Jasper attended medical school at Georgetown University School of Medicine, and completed his internship and residency in

[1] "Standard of care" means the use of that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. (*Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992.)

internal medicine at MS Hershey/Pennsylvania State University. He has been Board-certified in internal medicine, pulmonary disease, and critical care medicine. Dr. Jasper testified that he and respondent were colleagues "for years," and served together on the medical staff at two hospitals.

10. The First Amended Accusation includes five grounds for discipline based on respondent's prescribing of narcotics and opioids to two patients. Dr. Dardick testified that the standard of care requires a physician to administer the lowest dose of narcotics for the shortest period, only when indicated, only when alternative treatment is not successful, and only if the patient is appropriately monitored as to adverse effects. The administration of narcotics must be reflected in patient's medical record to enable the physician to refer back over time during ongoing treatment, and to inform another physician in the event of a change in health care providers.

11. Dr. Jasper testified that, in the past 10 years, the Board has shifted its philosophy about the administration of narcotics, specifically in reference to opioids. In the past, the Board issued newsletters advising physicians and surgeons that pain relief was not being addressed adequately. The Board instructed licensees to take extra units of continuing medical education specific to pain management, which encouraged opioids pain management. In his professional experience providing hospice care, Dr. Jasper testified, "It's the only thing that works." However, these practices led to what is generally described as the opioid epidemic, and a change in the Board's philosophy.

Care and Treatment of Patient SM

12. Patient SM first presented himself to respondent on December 13, 2006. At the time, Patient SM was a 67-year-old male with "chronic back pain" and "lower extremity weakness." (Ex. 13, p. 40.)

13. Patient SM also suffered from a persistent cough. For treatment of the cough, Patient SM repeatedly requested and was prescribed promethazine with codeine (Phenergan), an antihistamine and opiate listed as a Schedule V controlled substance.

14. According to the Controlled Substance Utilization Review & Evaluation System (CURES),[2] respondent prescribed and patient SM received refills approximately every two to three weeks between October 2012 and September 2015. Respondent's records show that he prescribed Phenergan to Patient SM as early as 2007.

[2] CURES is a database compiled and maintained by the California Department of Justice (DOJ) of all controlled substances prescribed and dispensed in the State of California. Pharmacies and direct dispensers of controlled substances are required to report prescription drug details to the DOJ, which in turn generates reports based on the reported data to authorized users.

15. Respondent's medical records for Patient SM include a "Consent for Chronic Opioid Therapy" and "Chronic Opioid Therapy Fact Sheet," two pages of pre-printed data relating to risks, rules, and prohibitions associated with treatment with opioids. (Ex. 21, p. 008-009.) Neither page is dated or signed by Patient SM.

16. On September 30, 2009, respondent ordered an x-ray of patient SM's chest. The radiologist noted the following impression: "Mild COPD[3] findings without acute cardiopulmonary disease." (Ex. 13, p. 73.) No evidence was presented to show that Patient SM underwent any other x-ray.

17. In Dr. Dardick's opinion, respondent's practice of medicine as it related to Patient SM was an extreme departure from the standard of care. The patient had a chronic cough that, according to Dr. Dardick, was never evaluated to rule out cancer, obstructive lung disease, allergies, assessable reflux or other causes. Narcotics were prescribed frequently for cough suppression only. Phenergan was an unacceptable treatment for such a long time due to risks of addiction, central nervous system side effects, sedation, dry mouth, respiratory depression, and constipation. No clear documentation indicates a cause for the cough, or shows that respondent discussed potential risks with patient.

18. In Dr. Jasper's opinion, respondent's diagnosis and prescribing for Patient SM were within the standard of care. Respondent adequately examined patient SM and prescribing Phenergan as a cough suppressant for years at a time is not uncommon. Respondent's medical records, including the chest x-ray in 2015 and other notes relating to allergic reactions, show that respondent examined Patient SM to rule out cancer and other potential causes.

19. Dr. Dardick's expert opinion is given more weight in Dr. Jasper's opinion. Although Dr. Jasper is certified in pulmonology, any professional advantage gained by the certification is negated by his past professional relationship with respondent. In determining the credibility of a witness, the administrative law judge may consider bias or motive. (Evid. Code, § 780, subd. (f).) Moreover, Dr. Jasper's opinion is based on philosophies and common practices that existed more than a decade ago, whereas the allegations involve misconduct occurring between 2012 and 2015. By virtue of his professional and educational background, and the rational and authoritative demeanor by which he testified, Dr. Dardick established himself to be a credible witness. The testimony of "one credible witness may constitute substantial evidence," including a single expert witness. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, at 1052.) The admissibility of expert evidence regarding an ultimate issue of fact is a discretionary matter for the trial court, to be evaluated in light of the facts of the particular case and the usefulness of the expert's opinions in arriving at the truth. (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907.) Dr. Dardick's expert opinion on the issue of the standard of care in this case is deemed substantial evidence and useful in arriving at the truth.

---

[3] COPD is the medical abbreviation for chronic obstructive pulmonary disease.

20. Accordingly, clear and convincing evidence establishes that respondent's care and treatment of patient SM was an extreme departure from the standard of care.

Care and Treatment of Patient EG

21. Patient EG was under respondent's care "for many years, since 2001" for fibromyalgia, chronic pain syndrome, vertigo, and chronic fatigue syndrome. (Ex. 20, p. 117.)

22. According to CURES, respondent regularly prescribed Patient EG various controlled substances, including hydrocodone (Vicodin), fentanyl, and alprazolam. (Ex. 4.)

23. After an office visit in December 2013, respondent began prescribing hydromorphone (Dilaudid), a Schedule II opioid, instead of Vicodin. Respondent did not document the reason for the change in medication in the medical charts maintained for Patient EG.

24. For a seven-month period beginning in January 2014, respondent prescribed and Patient EG received 10 refills of Dilaudid. During the same period, respondent increased the dosage of Dilaudid from 4 mg tablets to 8 mg tablets. Dilaudid is a dangerous drug[4] and, according to Dr. Dardick, a patient should be examined and monitored on a regular basis if prescribed the medication. Respondent prescribed the medication, and made these changes in dosage, without any adequate physical examination or documented office visit, except for notes respondent kept in a small spiral-bound pocketbook containing notes relating to other patients and general office matters. The pocketbook was not made part of Patient EG's medical record, but was instead kept in respondent's desk drawer for an unascertained period of time.

25. Respondent's medical records for Patient EG include a "Consent for Chronic Opioid Therapy" and "Chronic Opioid Therapy Fact Sheet," two pages of pre-printed data relating to risks, rules, and prohibitions associated with treatment with opioids. The written consent is not dated or signed by Patient EG.

26. According to respondent's testimony, he referred Patient EG on numerous occasions to a pain management specialist, but the patient was unable to afford the specialist; accordingly, he continued to treat her as a courtesy and without charging her for the office visits.[5] He further testified that he kept only shorthand notes in the pocketbook to prevent Patient EG from receiving a bill. Respondent and his office manager explained the office retains an outside billing service to prepare and issue all bills to patients. The billing service

---

[4] "Dangerous drug" means any drug unsafe for self-use in humans or animals, and includes any other drug that can be lawfully dispensed only on prescription. (Bus. & Prof. Code, § 4022, subd. (c).)

[5] Respondent's office manager testified that the typical charge for an office visit was $50 at the time of Patient EG's office visits.

generates a bill from the medical records and charges a six-percent commission on the amounts billed. The officer manager testified, in effect: "It's a major no-no to instruct the billing company not to bill a client. If we tell them not to send a bill, they question why. They will charge a commission on what they believe we collected if they have any reason to doubt us."

27. In Dr. Dardick's opinion, respondent's practice of medicine as it related to patient EG was "an extreme departure from the standard of care." (Ex. 24.) Respondent prescribed a dramatic increase in the potency of the narcotics without any documentation to explain the increase. Although the pocketbook notes reflect office visits, the notes are devoid of any clinical observations that would support such a dramatic change in medication.

28. In Dr. Jasper's opinion, respondent was practicing within the standard of care. He explained that a patient should be seen monthly if treated with Dilaudid. Although Dr. Jasper did not testify as to the adequacy of the notes in the pocketbook, he testified that the notes nonetheless reflect that respondent was monitoring Patient EG condition while taking Dilaudid.

29. Dr. Dardick's testimony was given more weight than Dr. Jasper's opinion. Dr. Jasper acknowledged that he does not generally treat patients with fibromyalgia, and that although he had prescribed Dilaudid to hospice patients and hospitalized patients, he could not recall having prescribed Dilaudid to walk-in patients in the regular course of his practice. The factors considered at Factual Finding 19 also tend to favor the testimony of Dr. Dardick and disfavor the testimony of Dr. Jasper.

30. Accordingly, clear and convincing evidence establishes that respondent's care and treatment of Patient EG constituted an extreme departure from the standard of care.

Maintenance of Medical Records

31. On June 24, 2015, respondent employed Manny Villegas as his office manager. Mr. Villegas has a degree in business and experience in different levels of healthcare administration. At the time of his employment, respondent had invested in an electronic medical record (EMR) system, but had not fully implemented the system into his practice. Most patient records were being kept in written charts, and according to Mr. Villegas, the state of respondent's filing and medical record keeping was "a disaster." Paper records were maintained in several locations throughout the office. Inconsistencies within patient medical records were a common occurrence.

32. On November 30, 2015, Patient SM signed an Authorization for Release of Medical Information (Consent), authorizing respondent to disclose all medical records maintained in the provision of services to Patient SM. (Ex. 9.) On December 7, 2015, Patient EG also signed a Consent. (Ex. 10.)

33. On December 11, 2015, Investigator Costello sent respondent a copy of the signed Consents and requested "a copy of the complete medical records" for both consumers, including "any writings relevant to [their] treatment." (Ex. 11-12.)

34. In response, respondent sent 77 pages of records relating to Patient SM (Ex. 13) and 44 pages of records relating to Patient EG (Ex. 14). On January 7, 2016, respondent certified under penalty of perjury that the documents sent for each patient were "the complete records for the period beginning 9/2012 and ending 12/2015." (Ex. 15-16.)

35. On May 10, 2016, Investigator Costello interviewed respondent. Respondent was represented by counsel. Lance Mohr, M.D., a District Medical Consultant, was permitted to ask respondent questions. During the 2-hour, 40-minute interview, it became apparent that respondent had not produced his entire medical record.

36. On May 12, 2016, respondent sent another 117 pages pertaining to Patient EG, and another 147 pages pertaining to Patient SM. This production of documents included the undated and unsigned written consents to opioid treatment described at Factual Findings 15 and 25, as well as records relating to prescriptions. He certified under penalty of perjury that the copied documents were "the complete records" for the patients, making reference to having "already provided prior production of balance of file." (Ex. 19.)

37. From June 13, 2016 to June 17, 2016, respondent and his staff participated in training to implement the EMR system. Respondent paid a service provider the sum of $1,500 for on-site computer training. (Ex. I.)

38. In May 2017, Manny Villegas, the office manager, discovered the pocketbook containing notes pertaining to Patient EG in a filing cabinet drawer, among "old papers that did not seem like a priority ... in a stack of papers crumpled up." Mr. Villegas discussed his discovery with respondent. They did not consider the pocketbook to be responsive or relevant to the Board's request for medical records relating to Patient EG. Respondent directed the office manager to transcribe all the handwritten notes pertaining to Patient EG into the EMR system. Mr. Villegas testified that the aim was to create a "more appropriate progress note in a more legal format."

39. On May 30, 2017, Manny Villegas printed all transcribed EMR notes. Each EMR note was not a verbatim transcription of the content of each pocketbook note; some EMR notes contained data not included in the pocketbook note or omitted data that was included in the pocketbook note. For example, for the office visit on February 23, 2013, the pocketbook note includes a diagnosis, but the EMR note does not include the diagnosis. Regarding an office visit on February 8, 2014, the pocketbook note refers to vertigo, but the EMR note makes no reference. The EMR notes include statements that were populated automatically by the computer software relating to the various stages of a complete physical examination, although the pocketbook notes contain no indication that a physical examination was performed to such an extent. For example, each EMR note states, "Heart rate and rhythm regular; no murmurs, rubs, gallops, or clicks; no lists, heaves, or thrills filled on palpation; heart location and apex normal; no peripheral edema." (Ex. 27.) However, the

pocketbook notes do not show that any vital signs were taken or that respondent performed any palpation on Patient EG. Manny Villegas, who has no medical training, used his personal judgment to interpret the pocketbook notes, some of which were illegible, to create the EMR notes. Respondent did not review the transcribed EMR notes. Each EMR note contained a statement, "This note has not been finalized and signed." (Ex. 27.)

40. On June 2, 2017, respondent's counsel delivered copies of the EMR notes to the Board.

LEGAL CONCLUSIONS

Standard of Proof

1. The standard of proof in an administrative action seeking to suspend or revoke a professional license is clear and convincing proof to a reasonable certainty. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.)

2. Clear and convincing evidence requires a finding of high probability. The evidence must be so clear as to leave no substantial doubt. It must be sufficiently strong to command the unhesitating assent of every reasonable mind. (*Christian Research Institute v. Alnor* (2007) 148 Cal.App.4th 71, 84.)

Statutory Grounds for Discipline

3. The Medical Practice Act governs the rights and responsibilities of the holder of a physician's and surgeon's certificate. (Bus. & Prof. Code, §§ 2000 et seq.) The state's obligation and power to regulate the professional conduct of its health practitioners is well settled. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564; *Fuller v. Board of Medical Examiners* (1936) 14 Cal.App.2d at p. 741.) The purpose of a disciplinary action is not to punish, but to protect the public. (*Watson v. Superior Court* (2009) 176 Cal.App.4th 1407, 1416.) Protection of the public is the highest priority for the Board in exercising its disciplinary authority and is paramount over other interests in conflict with that objective. (Bus. & Prof. Code, § 2001.1.)

4. The Board shall take action against any licensee who is charged with unprofessional conduct. (Bus. & Prof. Code, § 2234.)

5. Unprofessional conduct includes violating any provision of Medical Practice Act. (Bus. & Prof. Code, § 2234, subd. (a).)

Unprofessional Conduct – Gross Negligence

6. The first cause for discipline alleged unprofessional conduct and gross negligence. The second cause for discipline alleged repeated acts of negligence.

7. Unprofessional conduct includes gross negligence. (Bus. & Prof. Code, § 2234, subd. (b).) The Medical Practice Act does not define "gross negligence." Courts have described it as "the want of even scant care or an extreme departure from the ordinary standard of conduct." (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941; *Van Meter v. Bent Cons. Co.* (1956) 46 Cal.2d 588, 594.) The use of the disjunctive in the definition indicates alternative elements of gross negligence—"both need not be present before gross negligence will be found." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197.)[6]

8. Unprofessional conduct includes repeated acts of negligence, meaning two or more acts of negligence. (Bus. & Prof. Code, § 2234, subd. (c); *Zabetian v. Medical Bd* (2000) 80 Cal.App.4th 462.)

9. Cause exists to discipline respondent's certificate under Business and Professions Code sections 2234, subdivisions (b) and (c), because clear and convincing evidence was presented to show that respondent engaged in two or more acts of negligence that were an extreme departure from the standard of care. (Factual Findings 12-30.)

Unprofessional Conduct – Furnishing Dangerous Drugs without Examination

10. The third cause for discipline alleged unprofessional conduct by furnishing dangerous drugs without a proper examination.

11. Prescribing dangerous drugs without an appropriate prior examination and a medical indication constitutes unprofessional conduct. (Bus. & Prof. Code, § 2242, subd. (a).)

12. Cause exists to discipline respondent's certificate under Business and Professions Code sections 2242, subdivision (a), because clear and convincing evidence was presented to show that respondent prescribed dangerous drugs to Patient EG without a proper medical examination. (Factual Findings 21-30.)

Unprofessional Conduct – Failure to Comply with Record Request

13. The fourth cause for discipline alleged unprofessional conduct by failing to comply with the Board's reasonable request for the records of Patient EG.

14. Unprofessional conduct includes the failure to produce all documents requested by or on behalf of the Board within 15 business days of receipt of the request, except for good cause. (Bus. & Prof. Code, § 2225, subd. (a).)

15. Cause exists to discipline respondent's certificate under Business and Professions Code sections 2225, subdivision (a), because clear and convincing evidence was

---

[6] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App.3d 1040, 1058.

presented to show that respondent failed to produce all documents requested by or on behalf of the board within 15 days of receipt of the request and failed to show good cause for the delay. (Factual Findings 32-40.)

Unprofessional Conduct – Failure to Maintain Records

16. The fifth cause for discipline alleged unprofessional conduct by failing to maintain adequate and accurate medical records for Patient EG.

17. Unprofessional conduct includes the failure to maintain adequate and accurate records relating to the provision of services to a patient. (Bus. & Prof. Code, § 2266.)

18. Cause exists to discipline respondent's certificate under Business and Professions Code section 2266 because clear and convincing evidence was presented to show that respondent failed to maintain adequate and accurate records relating to Patient EG. (Factual Findings 21-40.)

Level of Discipline

19. In reaching a decision on the appropriate level of discipline, the Board must consider the guidelines entitled *Manual of Model Disciplinary Orders and Disciplinary Guidelines*, 12th Edition, 2016. (Cal. Code Regs., tit. 16, § 1361, subd. (a).) For the causes of discipline established herein, the guidelines recommend a maximum penalty of revocation and a minimum penalty of stayed revocation with five years of probation.

20. Deviating from the guidelines is appropriate where the facts of the particular case warrant such a deviation, such as the presence of mitigating factors. (Cal. Code Regs., tit. 16, § 1361, subd. (a).)

21. Rehabilitation requires a consideration of those offenses from which one has allegedly been rehabilitated. (*Pacheco v. State Bar* (1987) 43 Cal.3d 1041.) Rehabilitation is a state of mind, and the law looks with favor upon rewarding with the opportunity to serve one who has achieved reformation and regeneration. (*Id.*, at 1058.) The absence of a prior disciplinary record is a mitigating factor. (*Chefsky v. State Bar* (1984) 36 Cal.3d 116, 132, fn. 10.) Remorse and cooperation are mitigating factors. (*In re Demergian* (1989) 48 Cal.3d 284, 296.) While a candid admission of misconduct and full acknowledgment of wrongdoing may be a necessary step in the rehabilitation process, it is only a first step. A truer indication of rehabilitation is presented if an individual demonstrates by sustained conduct over an extended period of time that he is once again fit to practice. (*In re Trebilcock* (1981) 30 Cal.3d 312, 315-316.)

22. The task in disciplinary cases is preventative, protective and remedial, not punitive. (*In re Kelley* (1990) 52 Cal.3d 487.) Respondent has been licensed by the Board for 20 years with no history of prior discipline. Although his recordkeeping with respect to two patients was clearly and convincingly inadequate, respondent has employed an office manager with experience in health care administration, and invested in an EMR system and

training to improve his recordkeeping. Respondent was not motivated to profit from his overprescribing practices, treating Patient EG without charge.

23. Because the written consents were not included in the original production of documents, and neither patient signed or acknowledged the consent, doubt exists as to whether the patients were adequately disclosed of the risks and alternatives of treatment with narcotics. However, complainant did not allege the failure to obtain written consent to treatment as a ground for discipline. The evidence is merely additional evidence of inadequate recordkeeping.

24. In light of respondent's evidence of rehabilitation, outright revocation of respondent's certificate would be unduly punitive. On the other, the minimum penalty is not warranted because respondent's practices exposed two patients to substantial harm. Ordering respondent to undergo additional training in the areas of his misconduct, and imposing probationary terms to monitor and oversee his practice for seven years, will protect the public and further the remedial objectives of discipline.

ORDER

Certificate No. A 66211 issued to respondent is revoked. However, the revocation is stayed and respondent is placed on probation for seven years upon the following terms and conditions.

1. **Education Course.** Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational programs or courses which shall not be less than 40 hours per year, for each year of probation. The educational programs or courses shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational programs or courses shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. **Prescribing Practices Course.** Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure. A prescribing practices course

taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. **Medical Record Keeping Course.** Within 120 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure. A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later

4. **Professionalism Program (Ethics Course).** Within 180 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for renewal of licensure. A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. **Notification.** Within seven days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or

the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change in hospitals, other facilities, or insurance carrier.

6. **Supervision of Physician Assistants.** During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

7. **Obey All Laws.** Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments, and other orders.

8. **Quarterly Declarations.** Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. **General Probation Requirements.**

a. *Compliance with Probation Unit.* Respondent shall comply with the Board's probation unit

b. *Address Changes.* Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

c. *Place of Practice.* Respondent shall not engage in the practice of medicine in respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

d. *License Renewal.* Respondent shall maintain a current and renewed California physician's and surgeon's license.

e. *Travel or Residence Outside California.* Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than 30 calendar days. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

10. **Interview with the Board or its Designee.** Respondent shall be available in person upon request for interviews either at respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation

11. **Non-practice While on Probation.** Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

12. **Violation of Probation**. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. **License Surrender**. Following the effective date of this Decision, if respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his or her

license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. **Probation Monitoring Costs.** Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. **Completion of Probation.** Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

DATED: October 20, 2017

DocuSigned by:
Matthew Goldsby
8CC971E7989041F...

MATTHEW GOLDSBY
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
CHRISTINE R. FRIAR
Deputy Attorney General
State Bar No. 228421
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 897-6404
Facsimile: (213) 897-9395
Attorneys for Complainant

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Sept. 7 2017
BY _____ ANALYST

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: JULIO VICTOR GUZMAN, M.D. 4214 West Beverly Boulevard, Suite 212 Los Angeles, California 90004 Physician's and Surgeon's Certificate No. A 66211, Respondent.	Case No. 800-2014-010001 OAH No. 2017031098 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On August 7, 1998, the Board issued Physician's and Surgeon's Certificate number A 66211 to Julio Victor Guzman, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2018, unless renewed.

//

//

//

JURISDICTION

3. This First Amended Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"...."

//

//

6. Section 2242, subdivision (a), of the Code states:

"Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct."

7. Section 2225 of the Code states, in pertinent part:

"(a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

"(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

"(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

//

//

"(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

"...

"(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records."

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of Patients S.M. and E.G.[1] The circumstances are as follows:

10. Respondent is a solo practitioner, specializing in family medicine.

//

//

//

[1] In this First Amended Accusation, the patients are referred to by initial to protect their right of privacy. The patients' full names have been disclosed to Respondent.

Patient S.M.

11. Patient S.M. was a long-term patient of Respondent, first presenting for care in 2006. At the time, S.M. was 67 years old and had a history of chronic lower back pain and lower extremity weakness, among other conditions.

12. Commencing in 2007 and continuing through March of 2016, Respondent repeatedly and frequently prescribed Patient S.M. Phenergan with codeine, a Schedule V narcotic, for treatment of a chronic cough.

13. According to Respondent, he prescribed Phenergan with codeine to Patient S.M. because Patient S.M. told Respondent that other cough medication was ineffective.

14. According to Respondent, the most likely etiology for Patient S.M.'s chronic cough was either allergies or an upper respiratory tract infection.

15. The standard of care when presented with a patient with a chronic cough includes an initial physical examination and history sufficient to establish the etiology of the chronic cough, which could include cancer, obstructive lung disease, allergies and/or esophageal reflux. The etiology of the cough should then be used to determine the appropriate course of treatment. The use of a narcotic to chronically suppress a cough is generally not appropriate.

16. Respondent's failure to sufficiently evaluate and determine the etiology of Patient S.M.'s chronic cough, while consistently prescribing Patient S.M. Phenergan with codeine, constitutes an extreme departure from the standard of care.

Patient E.G.

17. Patient E.G. was a long-term patient of Respondent, first presenting for care in 2001. At that time, Patient E.G. was 44 years old and had a history of pain, including back pain, wrist pain and knee pain.

18. Respondent diagnosed her with fibromyalgia.

19. Over the course of Patient E.G.'s treatment with Respondent, he also diagnosed her with arthritis, major depression, anxiety disorder and obesity, among other conditions.

20. During the course of her treatment, Respondent prescribed her numerous controlled substances, including Vicodin (hydrocodone, a Schedule II opioid), Xanax (alprazolam, a

Schedule IV benzodiazepine), Phentermine (a Schedule IV amphetamine), Fiorinol (a Schedule III stimulant and muscle relaxant), Tramadol (a Schedule IV pain reliever), Effexor (an anti-depressant) and Duragesic patches (fentanyl, a Schedule II opioid).

21. According to Respondent, he encouraged Patient E.G. to see a pain management specialist, but she refused on the grounds that she could not afford it.

22. Respondent continued to manage Patient E.G.'s pain medication until she finally agreed to see a pain management specialist in 2015.

23. After an office visit in December of 2013, Respondent began prescribing Patient E.G. Dilaudid (hydromorphone, a Schedule II opioid) instead of Vicodin.

24. Respondent's reason for the change in her medication is not documented in Patient E.G.'s chart. Respondent states that Patient E.G. told him that the Dilaudid and Duragesic patches were more effective for treating her pain than Vicodin.

25. For the next seven months (January to July of 2014), Respondent continued to refill Patient E.G.'s Dilaudid and Duragesic patch prescriptions without any documented office visit. Patient E.G. received over ten refills for Dilaudid during this time period. Respondent also increased the dosage of Patient E.G.'s Dilaudid from 4 mg tablets to 8 mg tablets.

26. The standard of care in the care and treatment of a patient with chronic pain includes conducting an initial patient examination and history sufficient to establish the patient's symptoms, psychosocial assessment, screening for risk of drug abuse, previous evaluation, previous treatment and possible etiologies. Treatment of patients in chronic pain typically involves medication, but in conjunction with further evaluation, non-pharmacological interventions and appropriate referrals. The standard of care requires that when medications are prescribed that the doses and quantities be appropriate to treat a patient's symptoms, but also minimize the risk of dependency, abuse or drug diversion.

27. Respondent's care and treatment of Patient E.G. constitutes an extreme departure from the standard of care in that after she refused to see a pain management specialist, he continued to renew her medications for an extended period of time, including during a seven-month period in which he neither examined nor reassessed her condition.

28. Respondent's acts and/or omissions as set forth in paragraphs 10 through 27, inclusive above, whether proven individually, jointly, or in any combination therefore, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. As such, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

29. Respondent is subject to disciplinary action under Code section 2234, subdivision (c) in that he committed repeated negligent acts in his care and treatment of Patients S.M. and E.G. The circumstances are as follows:

30. Paragraphs 10 through 27 are incorporated by reference and re-alleged as if fully set forth herein.

31. Respondent's acts and/or omissions as set forth in paragraphs 10 through 27, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts in violation of section 2234, subdivision (c), of the Code. As such, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Furnishing Dangerous Drugs without Examination)

32. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in that he committed unprofessional conduct when he prescribed dangerous drugs to Patients S.M. and E.G. without a proper examination. The circumstances are as follows:

33. Paragraphs 10 through 27 are incorporated by reference and re-alleged as if fully set forth herein.

34. Respondent's acts and/or omissions as set forth in paragraphs 10 through 27, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct in violation of section 2242, subdivision (a), of the Code. As such, cause for discipline exists.

//

//

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Failure to Timely Comply with Request for Patient Records)

35. Respondent is subject to disciplinary action under Code sections 2234, subdivision (a) and 2225, subdivision (e) in that he committed unprofessional conduct when he failed to timely comply with the Board's request for the complete certified medical records of Patient E.G. The circumstances are as follows:

36. On or about December 11, 2015, an investigator for the Board mailed a letter to Respondent at his address of record requesting the complete certified medical records of Patient E.G.

37. The letter to Respondent stated:

"The requested records include, but are not limited to: progress notes, doctors' orders, nursing notes, x-ray films and reports, CT scans, EKG tracings, fetal monitoring strips, admission/discharge summaries, operative reports, progress notes, consultation reports, laboratory reports, photographs, billing records, medication logs, prescribing records, History and Physical Examination records, anesthesia reports, pathology reports, consent forms, correspondence, phone messages and any writings relevant to [E.G.'s] treatment." The letter further advised Respondent to contact the investigator should he have any questions regarding the request for records.

38. Enclosed with the letter was a written Authorization for Release of Medical Information signed by E.G. and a Certification of Records form for Respondent to complete and sign.

39. The letter ordered the records to be produced by December 28, 2015.

40. On or about December 22, 2015, the investigator received a message from Respondent's office requesting clarification on the Certification of Records. The investigator returned the call and left a message instructing the office to sign the Certification of Records form included with the letter requesting E.G.'s records.

41. On or about December 23, 2015, the investigator received 44 pages of uncertified medical records for Patient E.G. from Respondent.

42. On or about January 11, 2016, the investigator received a signed certification of records from Respondent for the 44 pages of records of Patient E.G., produced to the Medical Board on or about December 23, 2015. By signing the declaration, Respondent certified, under penalty of perjury, that the records produced were his complete records for Patient E.G. for the period of September 2012 through December 2015.

43. On May 17, 2016, Respondent and his attorney participated in an interview with the Board's investigative team pertaining to Respondent's care and treatment of Patients S.M. and E.G. At the interview, Respondent was specifically questioned regarding his lack of documentation for Patient E.G. during the period of January 2014 through July 2014 when E.G. had received multiple prescription refills for Dilaudid, a controlled substance. In response, Respondent stated, "No, there is no documentation, but [E.G.] told me that she feels better with the Dilaudid and the Duragesic patch combination." When questioned whether the lack of documentation during that period was due to E.G. possibly calling Respondent for a prescription rather than visiting his office in person, and whether there was any documentation showing telephone encounters, Respondent stated, "No, there is no documentation of a telephone encounter, but yeah, that must have been the case." Respondent later added, "And because [of] my extensive rela-- clinical relationship with [E.G.] for 15 years, I believe her and I wrote the prescriptions for her, even though they are not documented in the chart."

44. Respondent and his attorney also revealed at the interview that it was possible they had not yet produced all medical records for Patient E.G., and assured the Board's investigative team that they would go back and review Respondent's records to ensure that the Board had all records pertaining to E.G.

45. On or about May 24, 2016, the Board's investigator received a signed Certification of Records from Respondent for 117 pages of records for Patient E.G. By signing the declaration, Respondent personally certified, under penalty of perjury, that the records produced were his complete records for Patient E.G. for the period of September 2012 through May 2016. The investigator received the referenced records from Respondent's attorney on May 26, 2016.

//

46. On February 23, 2017, the Medical Board filed Accusation No. 800-2014-010001 against Respondent based upon deficiencies in his care and treatment of S.M. and E.G. On that same date, a true and correct copy of the Accusation was served via certified mail on Respondent, along with a Request for Discovery and a copy of Government Code sections 11507.5, 11507.6 and 11507.7.

47. On or about June 2, 2017, Respondent's attorney sent counsel for the Board Respondent's "Responses to Request for Discovery." Included were "Log of E.G. Visits" (3 pages) and "Miscellaneous Medical Notes for E.G." (49 pages). A Certification of Records was not included. Additionally, each of the "Miscellaneous Medical Notes for E.G." stated on its face that "This note has not been finalized and signed." And indeed, none of the "Miscellaneous Medical Notes for E.G." were signed by Respondent. The 49 pages of "Miscellaneous Medical Notes for E.G." were comprised of electronic "clinical notes" for the period of February 22, 2013 through November 23, 2015. These electronic "clinical notes" had not previously been produced to the Board during the course of the Board's investigation into Respondent's care and treatment of E.G., despite the investigator's request for such records and Respondent's certifications that the complete records of E.G. had been produced to the Board's investigator.

48. On August 29, 2017, counsel for Respondent sent counsel for Complainant 62 pages of Respondent's handwritten notes pertaining to his care and treatment of E.G., among other notes. These records, which had also not been previously produced to the Board, were also not accompanied by a Certification of Records.

49. Respondent's acts and/or omissions as set forth in paragraphs 36 through 48, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to 2234, subdivision (a) and 2225, subdivision (e) in that Respondent failed, in the absence of good cause, to comply with the Board's request for the complete certified medical records of Patient E.G. in a timely manner. As such, cause for discipline exists.

//

//

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Failure to Maintain Adequate and Accurate Records)

50. Respondent is subject to disciplinary action under Code sections 2234, subdivision (a), and 2266, in that he committed unprofessional conduct due to his failure to maintain adequate and accurate records for Patient E.G. The circumstances are as follows:

51. Paragraphs 10, 17-27, 36-48 are incorporated by reference and re-alleged as if fully set forth herein.

52. Respondent's acts and/or omissions as set forth in paragraphs 10, 17-27, 36-48, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct in violation of section 2266 of the Code. As such, cause for discipline exists.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 66211, issued to Julio Victor Guzman, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants, and advanced practice nurses;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: 9/7/2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

LA2016503396
62520680.doc